

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

4393

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04388

| | | | |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS 130 Prospect Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Victoria Middle Regalia Last Barnes | | 4. DATE OF DEATH Month 4 Day 10 Year 19 61 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 29, 1900 |
| 9. AGE (In years last birthday) 60 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Isaac Chambers | |
| 14. MOTHER'S MAIDEN NAME Etta Brown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. 218-20-7274 | | 17. INFORMANT Ethel Hamilton, Chestertown, Md. (daughter). | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia and atelectasis of left lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Complete paralysis DUE TO Operative clipping, aneurism, rt ant. cerebral artery INTERVAL BETWEEN ONSET AND DEATH about 3 days | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tracheotomy and arterial hypertension | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | |
| 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from Jan 24, 1961 to Apr 10, 1961 , that (I) (we) last saw the deceased alive and Apr 10, 1961 , and that death occurred at 6:20 PM from the causes and on the date stated above. | |
| 22a. SIGNATURE Robert W. Farr | | 22b. ADDRESS Chestertown, Md. | |
| 22c. PHYSICIAN'S NAME (Type) Robert W. Farr | | 22d. ADDRESS Chestertown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Apr. 15, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY Janes Cemetery | | 23d. LOCATION (City, town, or county) (State) near Chestertown, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walby | | 25a. REC'D BY REGISTRAR APR 18 '61 | |
| ADDRESS Chestertown, Md. | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

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1993

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12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4396

04389

| | | | | | |
|---|--|--|---|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown - rural c. LENGTH OF STAY IN 1b 3 1/2 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Annes Hospital | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New York b. COUNTY New York c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) New York, 24 d. STREET ADDRESS 16 W. 86th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Victor Middle Danon Last Danon | | | 4. DATE OF DEATH Month April Day 9 Year 19 61 | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Staff Writer - USIA | | 10b. KIND OF BUSINESS OR INDUSTRY US Govt. | | 11. BIRTHPLACE (State or foreign country) Tel Aviv, Israel | |
| 13. FATHER'S NAME Joseph Danon | | 14. MOTHER'S MAIDEN NAME Anna Haim | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. Korea | | 17. INFORMANT Joseph Danon 16 W. 86th St., N.Y.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple severe injuries including fracture of the base of skull. DUE TO 3 1/2 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Was pilot in single engine plane which crashed near Chestertown, Md. with the above noted injuries. (c) Death occurred 10:34 P.M. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour 8:20 P.M. Month, Day, Year 4/9 1961 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rural, Chestertown | |
| | | | | 20f. (City or town) Kent (County) Md. (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Robert W. Farr | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Robert W. Farr, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 4/10/61 DATE SIGNED | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Chestertown, Md. | | | |
| | | Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-16-61 | | 22c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden | |
| | | | | 22d. LOCATION (City, town, or country) Falls Church, Virginia (State) | |
| 23. FUNERAL DIRECTOR Willis Wells | | ADDRESS Chestertown, Md. | | 24a. REC'D BY REGISTRAR APR 17 '61 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

100-100000

(M)

5200

Chatterbox - Rural 34 hours New York, 20

Robert & Susan Jones Hospital

10 W. 80th St.

Victor

Woman

April 2

01

Wife White

4/2/30

35

Still under - 27A

22 Ave.

12 Ave. 1st

Wife

Wife

(I)

Joseph Jones 10 W. 80th St., N.Y.C.

Robert Jones

Visible severe injuries including

fracture of the base of skull.

The list of single bones which are broken

Chatterbox, 10, with the above noted injuries.

Death occurred 10:30 P.M.

100-100000

Chatterbox - Rural 34 hours New York, 20

Robert

01

4/10/31

Chatterbox, 10.

Robert W. Jones, N.Y.C.

100-100000

Chatterbox - Rural 34 hours New York, 20

Robert W. Jones, N.Y.C.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4397

04390

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 1 hour d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne, Hospital | | 2. USUAL RESIDENCE (Where deceased lived. (If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall d. STREET ADDRESS 2 Spring Cove Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Laura Elizabeth Downey | | 4. DATE OF DEATH April 26 19 61 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 14, 1890 |
| 9. AGE (In years last birthday) 70 | | 10. IF UNDER 1 YEAR Months Days Hours Min. 2 years | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Alec Shaney | | 14. MOTHER'S MAIDEN NAME Mary Debering | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 579-22-6919 | |
| 17. INFORMANT Hospital records, Chestertown, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 170X DUE TO Carcinoma of left breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO lying cause last. (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 years 3 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-3-59 to 4-26 19 61 , that (I) (we) last saw the deceased alive on 4-26 19 61 , and that death occurred at 5 PM , from the causes and on the date stated above. | | 22a. SIGNATURE A.C. Dick M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 4-26-61 | |
| 22c. PHYSICIAN'S NAME (Type) A.C. Dick, M.D. | | 22d. ADDRESS Chestertown, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 4/29/61 | 23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel | 23d. LOCATION (City, town, or county) (State) Rock Hall Md |
| 24. FUNERAL DIRECTOR'S SIGNATURE Eliza L. Sam Church Hill Md | | 25a. REC'D BY REGISTRAR MAY 3 '61 DATE 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4398

CERTIFICATE OF DEATH

Reg. Dist. No. 04391

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hosp. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Ada S. Middle Ford Last | | 4. DATE OF DEATH Month April Day 28 Year 1961 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 17 1881 |
| 9. AGE (In years last birthday) 79 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) homemaking | | 10b. KIND OF BUSINESS OR INDUSTRY home | |
| 11. BIRTHPLACE (State or foreign country) Rock Hall, Kent Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Pearce | | 14. MOTHER'S MAIDEN NAME Anna E. Sappington | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| INFORMANT Address B. Frank Ford Rock Hall, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | INTERVAL BETWEEN ONSET AND DEATH 1 week |
| 21. I certify that I attended the deceased from Apr 27 , 19 61 , to Apr 28 , 19 61 , that I last saw the deceased alive on Apr 28 , 19 61 , and that death occurred at 11 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Chestertown Md 4.29.61 | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| ACTUAL SIGNATURE A. T. KEEFE | | M.D. A. T. KEEFE | |
| PHYSICIAN'S NAME (Type) A. T. KEEFE | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Apr. 30/61 | 22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem. | 22d. LOCATION (City, town, or county) (State) Rock Hall, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams | | ADDRESS Chestertown, Md. | |
| 24a. REC'D BY REGISTRAR DATE MAY 2 '61 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Knead | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4399

04392

| | | | | | | | | |
|---|--|---|--|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | | c. LENGTH OF STAY IN 1b 4 days | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital | | | | d. STREET ADDRESS RFD | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Florence Middle Alice Last Green | | | | 4. DATE OF DEATH Month April Day 5 Year 19 61 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 4/11/98 | | |
| 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months 6 Days 2 | | IF UNDER 24 HRS. Hours 0 Min. 0 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Burgess | | | | 14. MOTHER'S MAIDEN NAME Sadie Diggs | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 215 20 0106 | | 17. INFORMANT Address Russie Wilson, Worton, Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia (Hemolytic bacillus) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-1-61 19 61 , to 4-5 19 61 , that (I) (we) last saw the deceased alive on 4-5 19 61 , and that death occurred at 7:20pm from the causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE <i>A.C. Dick</i> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 4-5-61 | | |
| 22c. PHYSICIAN'S NAME (Type) A.C. Dick, M.D. | | | | 22d. ADDRESS Chestertown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4/8/61 | | 23c. NAME OF CEMETERY OR CREMATORY Butlertown, Md. | | 23d. LOCATION (City, town, or county) (State) near- Worton, Md. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest W. Wadley</i> | | | | ADDRESS Chestertown, Md. | | 25a. REC'D BY REGISTRAR APR 10 '61 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i> | | | | |

ap

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04393

| | | | |
|--|---|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lynch c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynch d. STREET ADDRESS Lynch e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Karl Karbaum | | 4. DATE OF DEATH Month April Day 19 Year 1961 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/24/1891 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign language instructor | | 10b. KIND OF BUSINESS OR INDUSTRY New York | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank Karbaum | | 14. MOTHER'S MAIDEN NAME Minnie Shutte | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Jennie Karbaum, Lynch, Maryland | |
| 17. INFORMANT Jennie Karbaum, Lynch, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Coronary Thrombosis DUE TO (b) Attack of precordial pain associated with shock and cold drenching sweat about 11:00 P.M. April 18, 1961. DUE TO (c) Death occurred 10:30 A.M. April 19, 1961. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: None | | | |
| INTERVAL BETWEEN ONSET AND DEATH 12 hours | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Robert W. Farr | | DATE SIGNED 4/21/61 | |
| EXAMINER'S NAME (Type) Robert W. Farr, M. D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, or other disposal (Specify) | | 22b. DATE THEREOF | |
| Burial | | April 22, 1961 | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or country) (State) | |
| Indersville Cemetery | | Indersville Ind. | |
| 23. FUNERAL DIRECTOR Edward Yellow Millington Ind. | | ADDRESS | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE Arthur L. Knaus | |
| DATE APR 25 '61 | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 shall be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

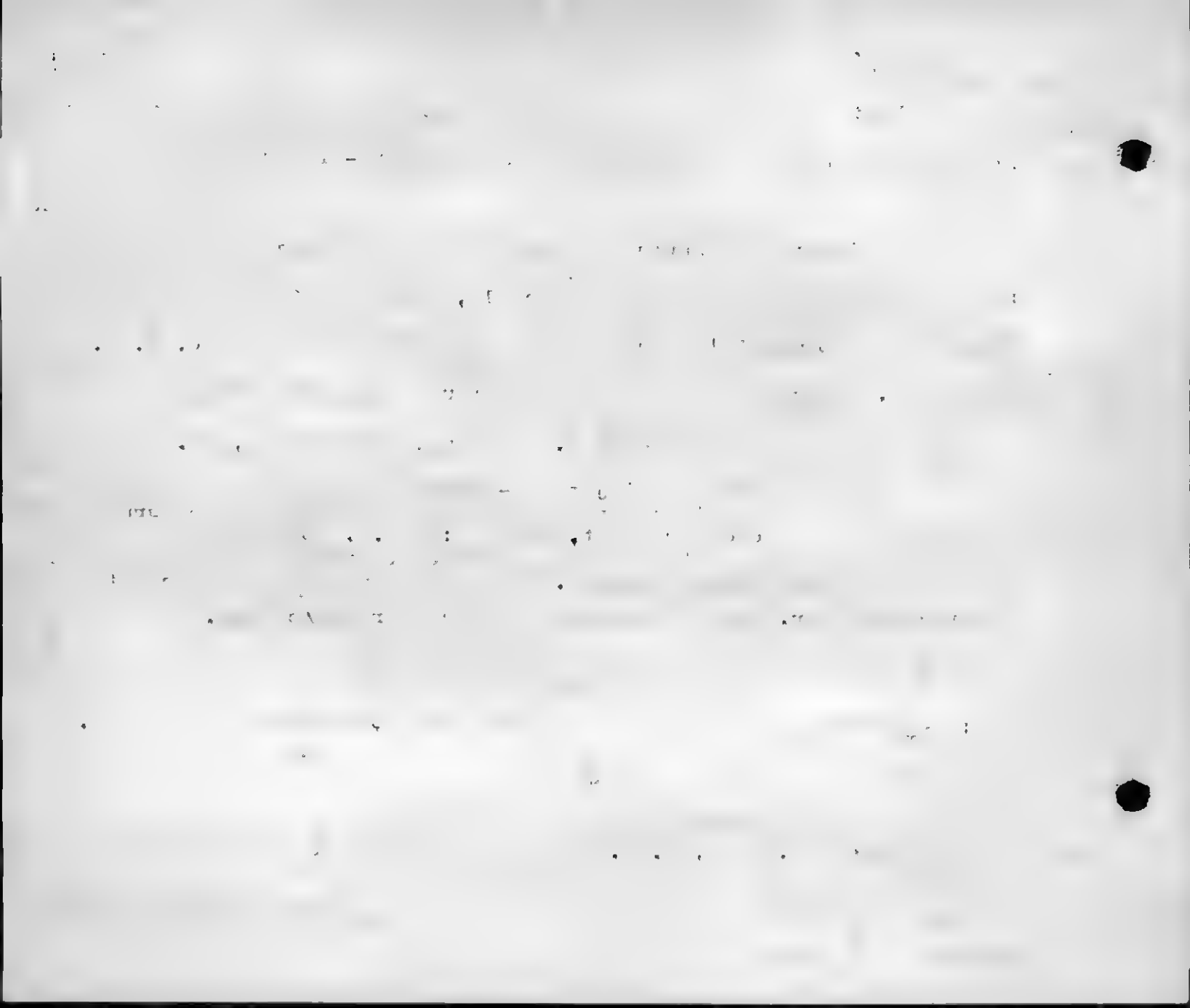
VS. A15ME
SM 7/59

4401
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04394

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Queen Annes | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mear Chestertown | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millington - rural | |
| c. LENGTH OF STAY IN 1b transient | | d. STREET ADDRESS | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Richard Irvin Lindsay | | 4. DATE OF DEATH April 22 1961 | |
| 5. SEX male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct 19, 1937 |
| 9. AGE (In years last birthday) 23 yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Campbell's Soup | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Walter I. Lindsay | | 14. MOTHER'S MAIDEN NAME Gertrude Elizabeth Pearce | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. 215-36-1476 E. | |
| 17. INFORMANT Fellows, Millington, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal injuries - chest and abdomen DUE TO Was in a car which failed to make a sharp turn in the road and upset, about 1:45 A.M. Deceased was thrown from the car & came to rest with the car resting on his abdomen & chest. He was dead when first seen after moving the car. Spinal fluid was removed for toxicology. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I moving the car. Spinal fluid was removed for toxicology. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH short | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 1:45 p.m. 4/22 1961 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway, rural | | 20f. (City or town) (County) (State) Chestertown Kent Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cau <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Robert W. Farr, M. D. | | DATE SIGNED 4/22/61 | |
| EXAMINER'S NAME (Type) Robert W. Farr, M. D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 24-61 | |
| 22c. NAME OF CEMETERY OR CREMATORY Millington Cem. | | 22d. LOCATION (City, town, or country) (State) Millington, Kent Co., Md. | |
| 23. FUNERAL DIRECTOR Edward Fellows, Millington, Md. | | 24a. REC'D BY REGISTRAR APR 25 '61 | |
| 24b. REGISTRAR'S SIGNATURE William S. Thomas | | | |

MEDICAL CERTIFICATION



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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402
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04395

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Kent | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | | | c. LENGTH OF STAY IN 1b 19 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Elizabeth Middle Estelle Last Peacock | | | | 4. DATE OF DEATH Month 4 Day 8 Year 19 61 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/8/77 | |
| 9. AGE (In years lost birthday) yrs 83 | | 10. IF UNDER 1 YEAR Months Days Hours Min | | 11. IF UNDER 24 HRS. Months Days Hours Min | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | | | |
| 13. FATHER'S NAME Edward Fallowfield | | | | 14. MOTHER'S MAIDEN NAME Annie Cooper | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 063-09-8854 | | | |
| 17. INFORMANT Elizabeth E. Peacock, Patient. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 176.1 DUE TO Inoperable squamous cell carcinoma of vagina Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 18 months DUE TO (c) 18 months | | | | | | INTERVAL BETWEEN ONSET AND DEATH 18 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1-26 to 4-8 , 19 61 , that (I) (we) last saw the deceased alive on 4-8 , 19 61 , and that death occurred at 3:20 pm from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE A.C. Dick | | | | 22b. DATE SIGNED 4-11-61 | | | |
| 22c. PHYSICIAN'S NAME (Type) A.C. Dick, M.D. | | | | 22d. ADDRESS Chestertown, Maryland | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 4/12/61 | | 23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory | | 23d. LOCATION (City, town, or county) (State) Wilmington, Delaware | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John H. Wells | | | | 25a. REC'D BY REGISTRAR APR 18 1961 | | | |
| ADDRESS Chestertown, Md. | | | | 25b. REGISTRAR'S SIGNATURE Clinton L. Howard | | | |

I



CERTIFICATE OF DEATH

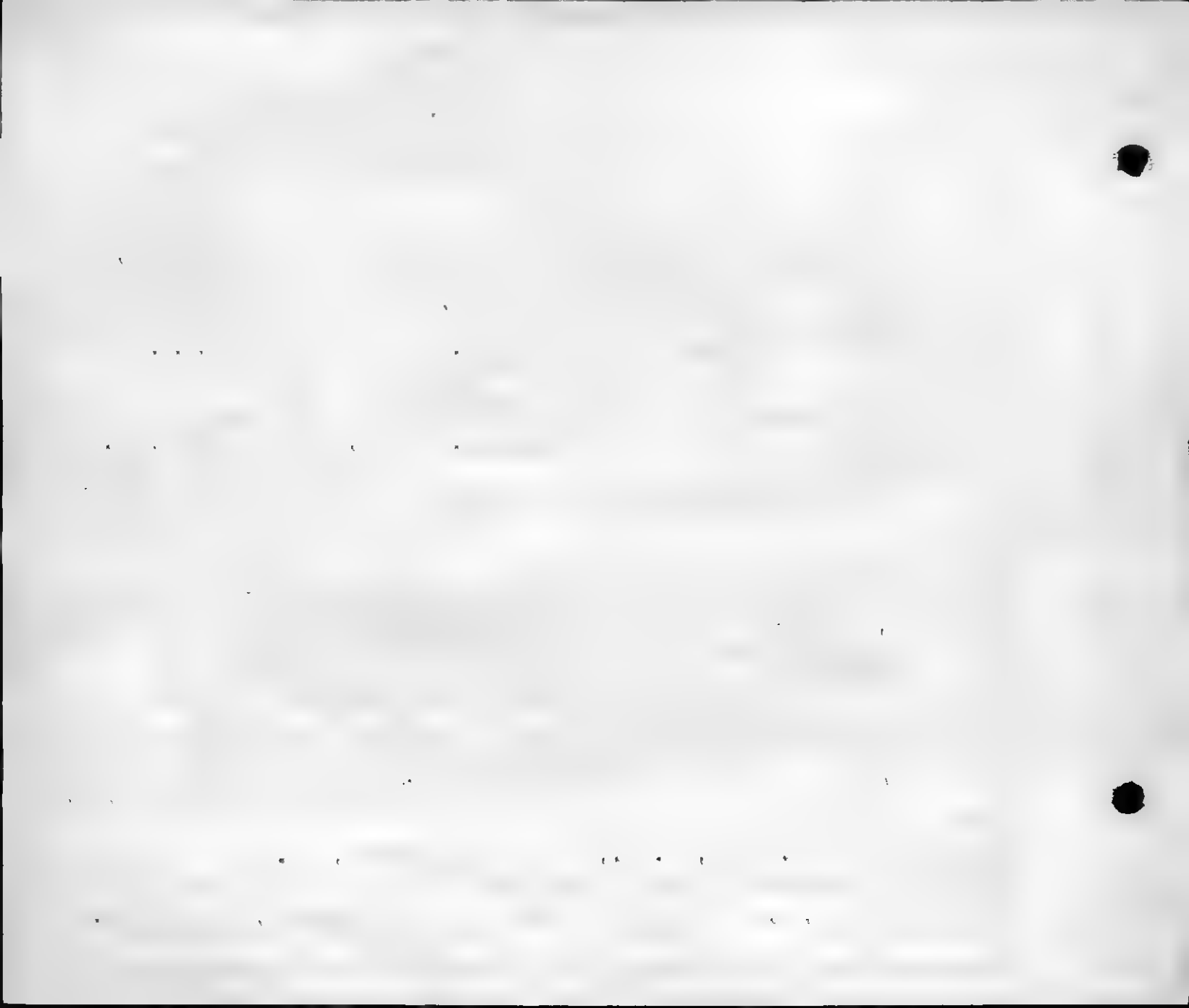
04396

Reg. Dist. No.

| | | | | | |
|---|----------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville d. STREET ADDRESS / | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Lidle Middle Davis Last Rhoades | | 4. DATE OF DEATH Month April Day 28 Year 19 61 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 20, 1874 | 9. AGE (In years last birthday) 87 yrs | IF UNDER 1 YEAR: Months 8 Days 28 Hours 19 Min. 61 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Del. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Corneilus Davis | | 14. MOTHER'S MAIDEN NAME Lizza Draper | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT William B. Cleaver, Kennedyville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatitis DUE TO Stricture of bile duct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia, Cachexia due to vomiting & inability to eat | | | | | INTERVAL BETWEEN ONSET AND DEATH 27 days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 61 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) / | |
| 20f. (City or town) / | | 20g. (County) / | | 20h. (State) / | |
| 21. I certify that I attended the deceased from 4/10 , 19 61 , to 4/28 , 19 61 , that I last saw the deceased alive on 4/28 , 19 61 , and that death occurred at 3:20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) / DATE SIGNED 4/29/61 | | | | | |
| ACTUAL SIGNATURE Robert W. Farr M.D. | | PHYSICIAN'S NAME (Type) Robert W. Farr, M. D., Chestertown, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 30, 1961 | | 22c. NAME OF CEMETERY OR CREMATORY Forrest Cemetery | |
| 22d. LOCATION (City, town, or county) Middletown, Del. | | 22e. (State) Del. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edward H. Collins | | ADDRESS Millington, Md. | | 24a. REC'D BY REGISTRAR MAY 2 '61 | |
| 24b. REGISTRAR'S SIGNATURE Charles S. Knaus | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

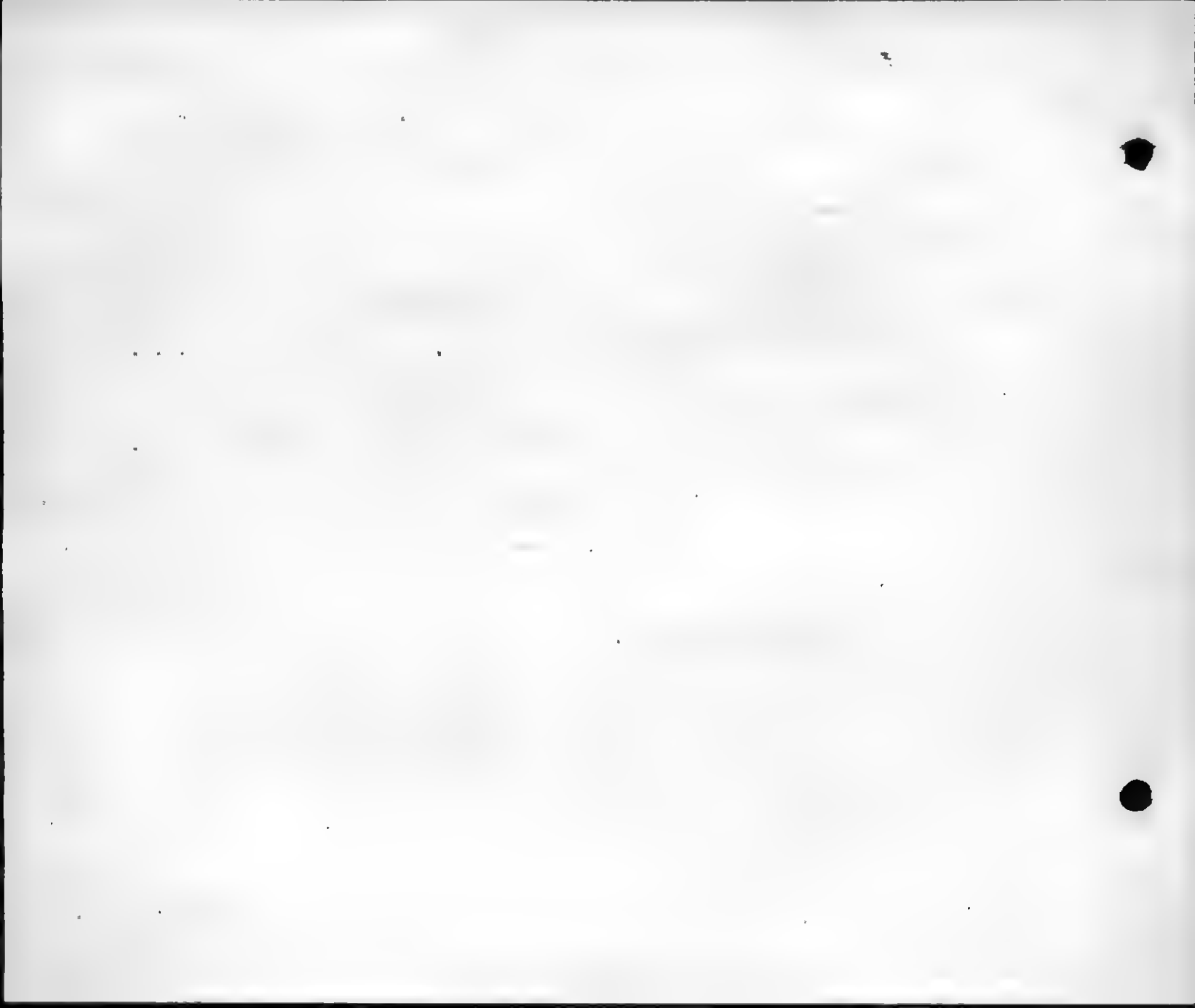
CERTIFICATE OF DEATH

Reg. Dist. No. **04397**

4404

| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH a. COUNTY Kent MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sassafras | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sassafras | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home | | d. STREET ADDRESS / | |
| 3. NAME OF DECEASED (Type or print) First Raymond Middle Ringgold Last Ringgold | | 4. DATE OF DEATH Month April Day 26 Year 1961 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 24, 1884 |
| 9. AGE (In years last birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver | | 10b. KIND OF BUSINESS OR INDUSTRY School Bus | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Perry Ringgold | | 14. MOTHER'S MAIDEN NAME Emma Driver | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. INFORMANT Elizabeth Ringgold, Sassafras, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe generalized senility. | | | |
| INTERVAL BETWEEN ONSET AND DEATH 12 hours years. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from 5 Apr. 1961 to 26 Apr. 1961 , that I last saw the deceased alive on 26 Apr. 1961 , and that death occurred at 12:30 p.m. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Wallace Obenshain M.D. | | ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 27 April | |
| PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D. | | Cecilton, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF April 29, 1961 | 22c. NAME OF CEMETERY OR CREMATORY John Wesley Cemetery | 22d. LOCATION (City, town, or county) Sassafras, Kent Co; Md. (State) _____ |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Mellington, Md. | | 24a. REC'D BY REGISTRAR MAY 1 '61 DATE | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

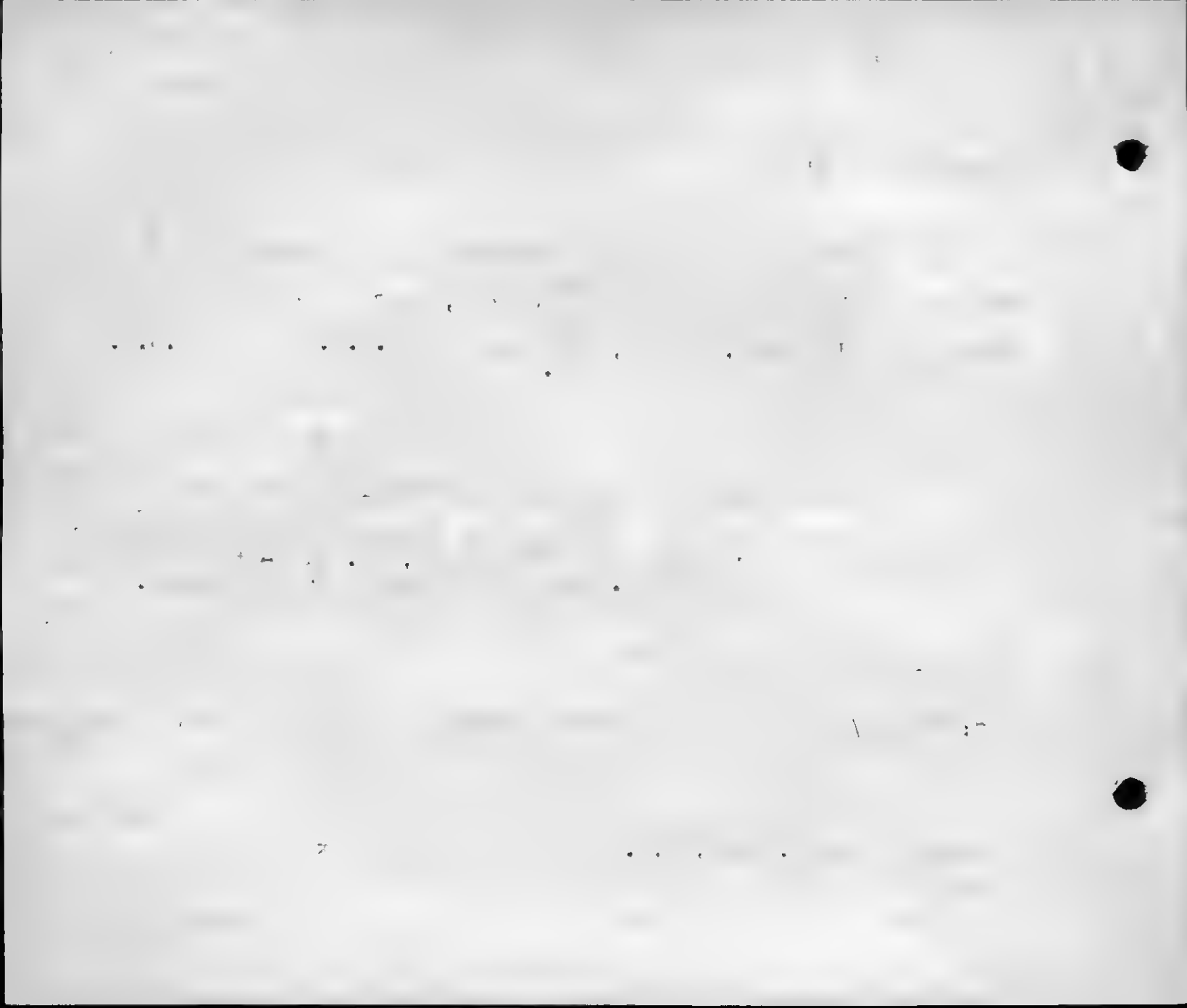
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Kent | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown Rural | | c. LENGTH OF STAY IN It MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DeC. | |
| 3. NAME OF DECEASED (Type or print) Sarah | | First | | Middle Schmulman | | Last | | 4. DATE OF DEATH Month April Day 9 Year 19 61 | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 5, 1927 | | 9. AGE (In years, last birthday) 33 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician Natl Inst. | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Jack Schmulman | |
| 14. MOTHER'S MAIDEN NAME Ethel Kaminoff | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Frances Myman | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple severe injuries including fracture of base of skull DUE TO (b) She was a passenger in a single engine plane which crashed near Chestertown, Md. with the above noted injuries. Death was probably instantaneous. DUE TO (c) Interval between onset and death: none | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | 20c. TIME OF INJURY Month, Day, Year 7:20 p.m. 4/9 19 61 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Near Chestertown | | 20f. (City or town) Kent | | (County) Maryland | | (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| 21. ACTUAL SIGNATURE Robert W. Farr, M.D. | | 21. EXAMINER'S NAME (Type) Robert W. Farr, M.D. | | 21. ASSISTANT MEDICAL EXAMINER APR 11/1961 | | 21. DEPUTY MEDICAL EXAMINER | | 21. DATE SIGNED April 9/1961 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/11/61 | | 22c. NAME OF CEMETERY OR CREMATORY Eden Memorial Park | | 22d. LOCATION (City, town, or country) Los Angeles, Calif. | | 22e. REC'D BY REGISTRAR APR 18 '61 | |
| 22f. REGISTRAR'S SIGNATURE Arthur L. House | | 22g. REGISTRAR'S NAME Arthur L. House | | 22h. REGISTRAR'S ADDRESS Chestertown, Md. | | 22i. REGISTRAR'S PHONE NO. | | 22j. REGISTRAR'S EXPIRATION DATE | |

04398

473

15. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

907 Schumacher Dr. Los Angeles, Calif.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

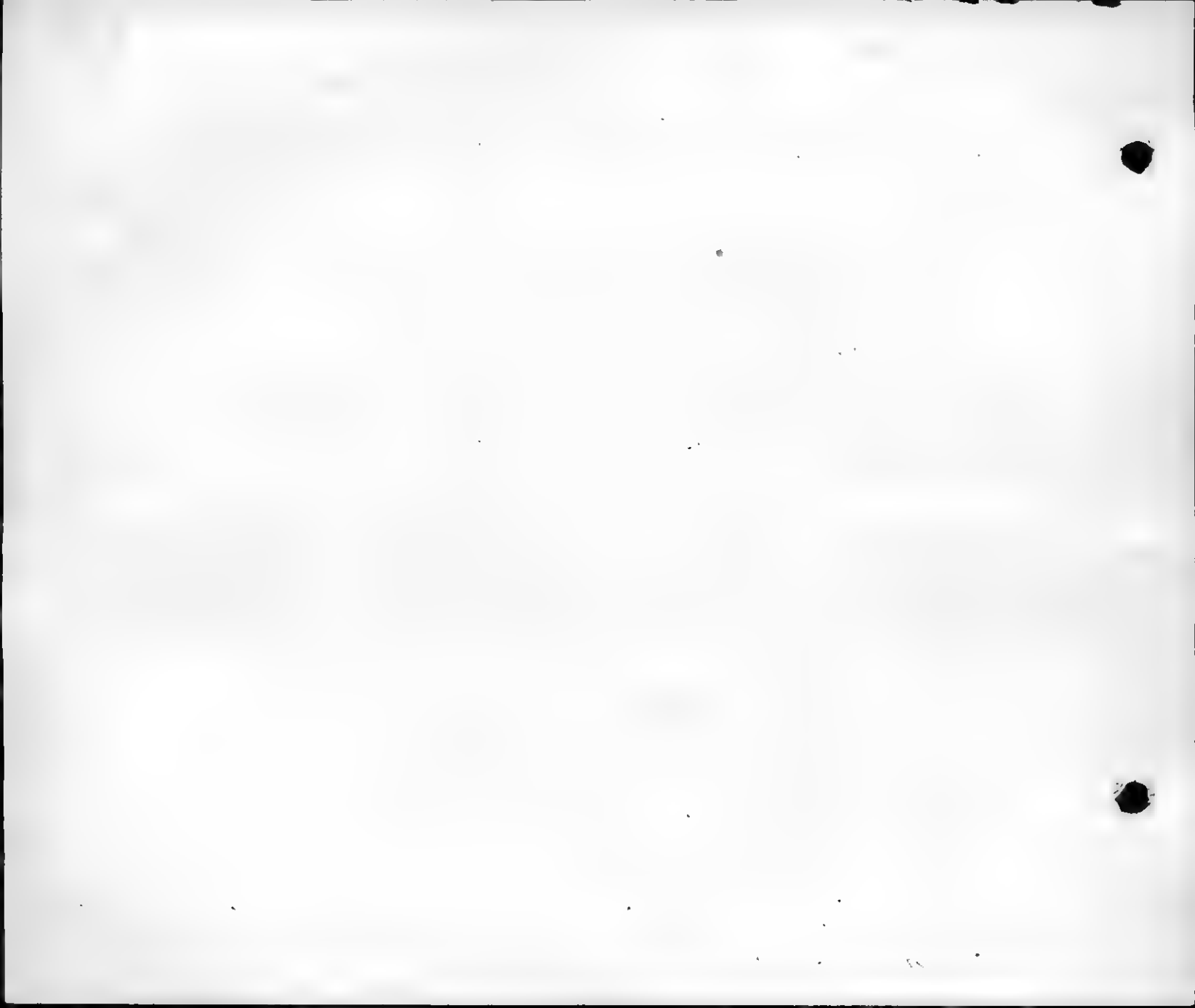
4406

CERTIFICATE OF DEATH

Reg. Dist. No. 04399

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Kent County</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Kent</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall, Md</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>1 Green Lane</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie Sewell</u> | | 4. DATE OF DEATH Month Day Year <u>4 19 1961</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 12 1872</u> |
| 9. AGE (In years last birthday) <u>89</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>US</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Rodolph Buskey</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u> <u>194X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20b. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | |
| 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20e. (City or town) | | 20f. (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>E. Kester</u> | | DATE SIGNED _____ | |
| PHYSICIAN'S NAME (Type) <u>E. KESTER</u> | | ADDRESS (Street, city or town, state) <u>Rock Hall Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>4/20/61</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u> | 22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> | | 24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> | |
| ADDRESS <u>Church Hill Md</u> | | DATE <u>APR 24 '61</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



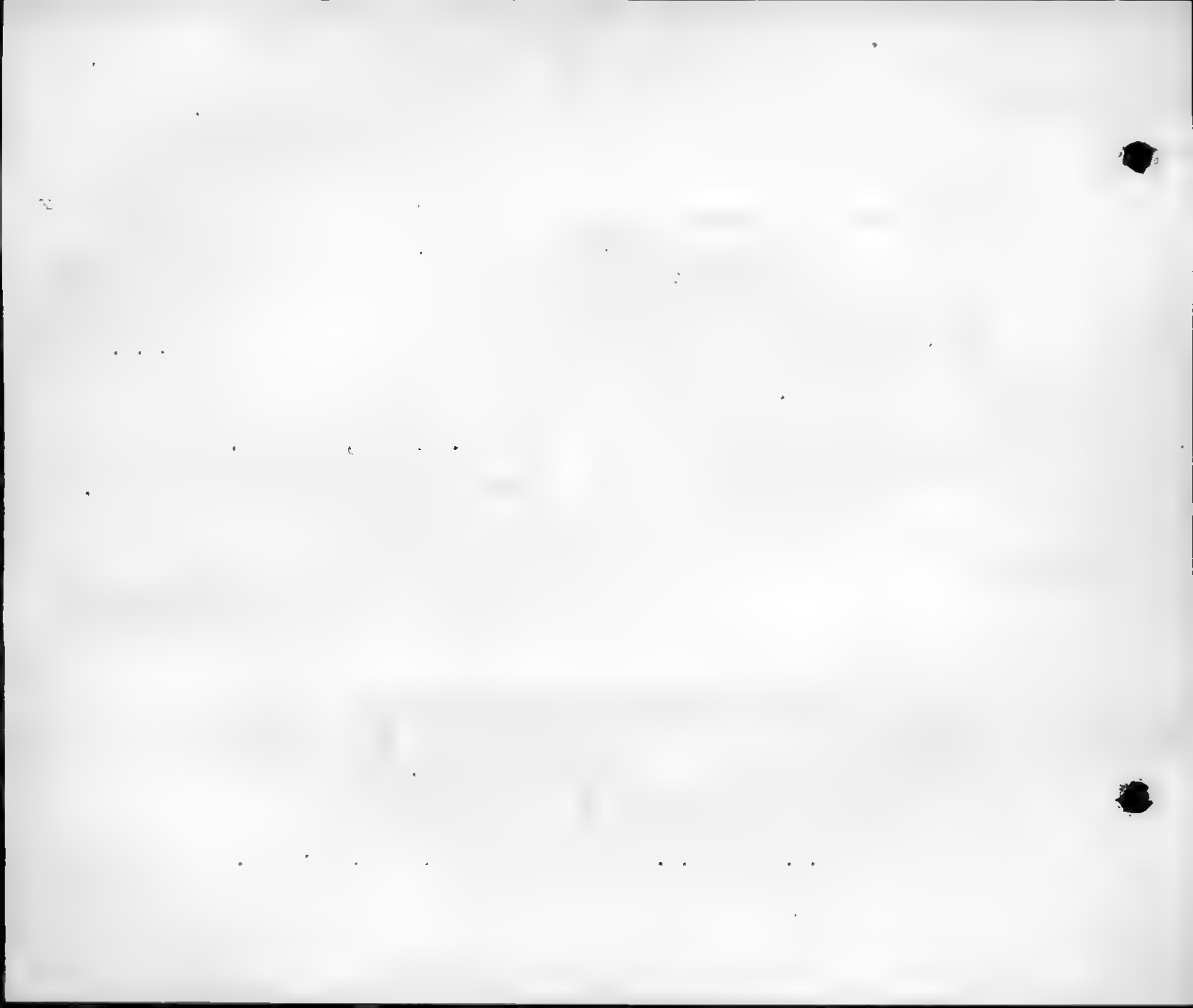
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
4407

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04400

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | | | c. LENGTH OF STAY IN 1b 5 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First William Middle H. Last Toulson | | | | 4. DATE OF DEATH Month April Day 13 Year 1961 | | | |
| 5. SEX male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/30/76 | |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min 84 | | IF UNDER 24 HRS Months 84 Days 84 Hours 84 Min 84 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Agriculture | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Thomas W. Toulson | | | | 14. MOTHER'S MAIDEN NAME Amanda Baker | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. William H. Toulson, (Patient). | | 17. INFORMANT William H. Toulson, (Patient). | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery infarct 4200 DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH 30 min. 2 years 10 years | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-8-1961 to 4-13-1961 , that (I) (we) last saw the deceased alive on 4-12-1961 , and that death occurred at 2:05 am from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE A.C. Dick | | | | 22b. ADDRESS Chestertown, Maryland. | | | |
| 22c. PHYSICIAN'S NAME (Type) A.C. Dick, M.D. | | | | 22d. ADDRESS Chestertown, Maryland. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF Apr. 15, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY Chester Cem. | |
| 23d. LOCATION (City, town, or county) (State) Chestertown, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells | | | | 25a. REC'D BY REGISTRAR APR 17 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Fries | |



CERTIFICATE OF DEATH

Reg. Dist. No. **04401**

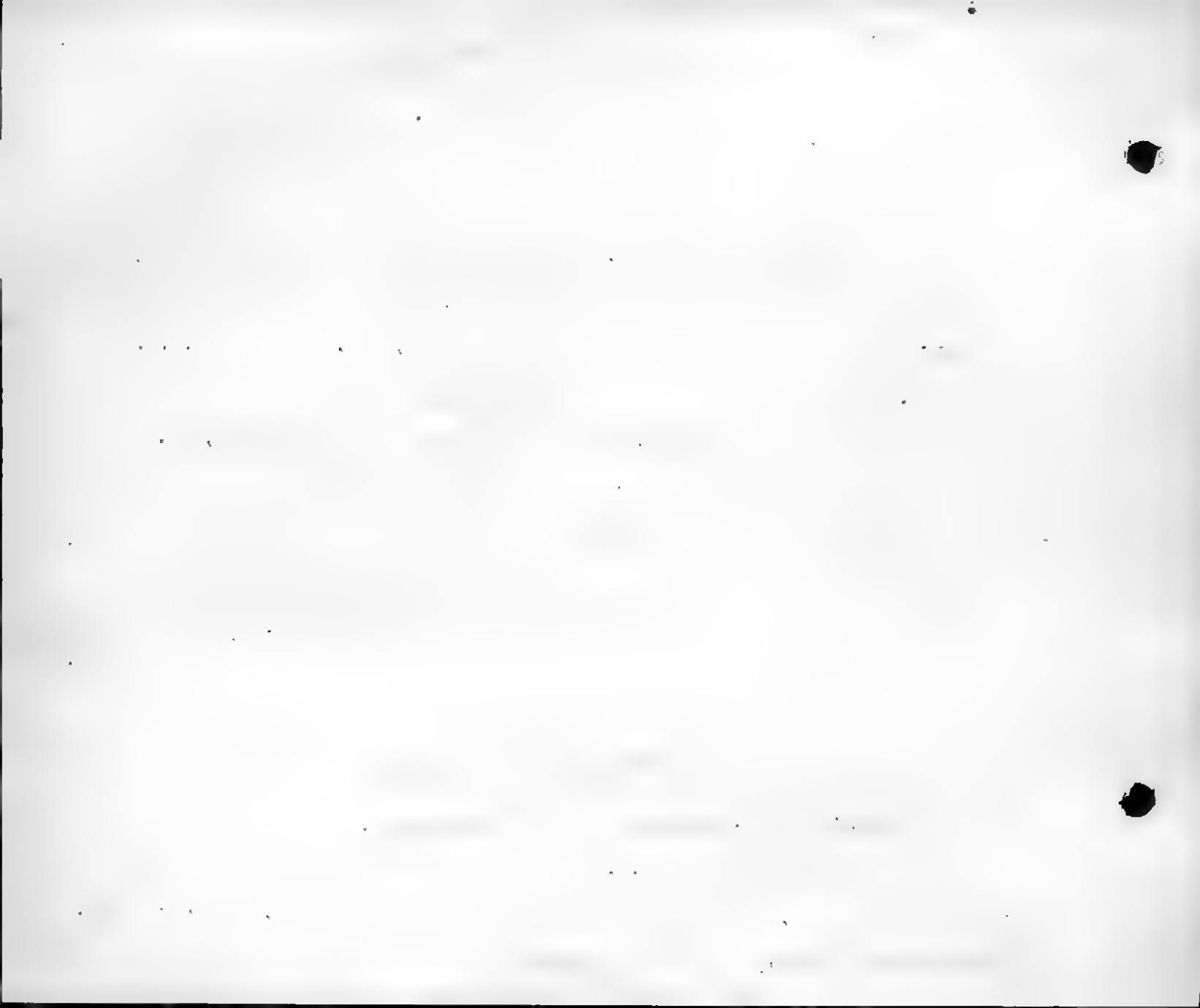
4408

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Lula Middle M. Last Wallace | | 4. DATE OF DEATH Month April Day 4 Year 1961 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 27, 1895 |
| 9. AGE (In years last birthday) 65 yrs. | | 10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Millington, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George H. Dixon | | 14. MOTHER'S MAIDEN NAME Sarah Smith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-20-0586 | |
| INFORMANT Ward Wallace, | | Address Millington, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Emphysema DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Extreme anorexia, malnutrition generalized arteriosclerosis, intestinal 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH 3 days years. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) claudification. | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from June 16 , 19 60 to 4 Apr , 19 61 , that I last saw the deceased alive on 4 Apr , 19 61 , and that death occurred at 3:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Wallace Chouhain M.D. Cecilton, Md. 5 Apr 61 PHYSICIAN'S NAME (Type) Wallace Chouhain, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 7, 1961 | |
| 22c. NAME OF CEMETERY OR CREMATORY Millington Cemetery | | 22d. LOCATION (City, town, or county) _____ (State) _____ Millington, Kent Co; Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edward J. Fellows | | 24a. REC'D BY REGISTRAR DATE APR 10 '61 | |
| ADDRESS Millington, Md. | | 24b. REGISTRAR'S SIGNATURE William S. Thomas | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4409

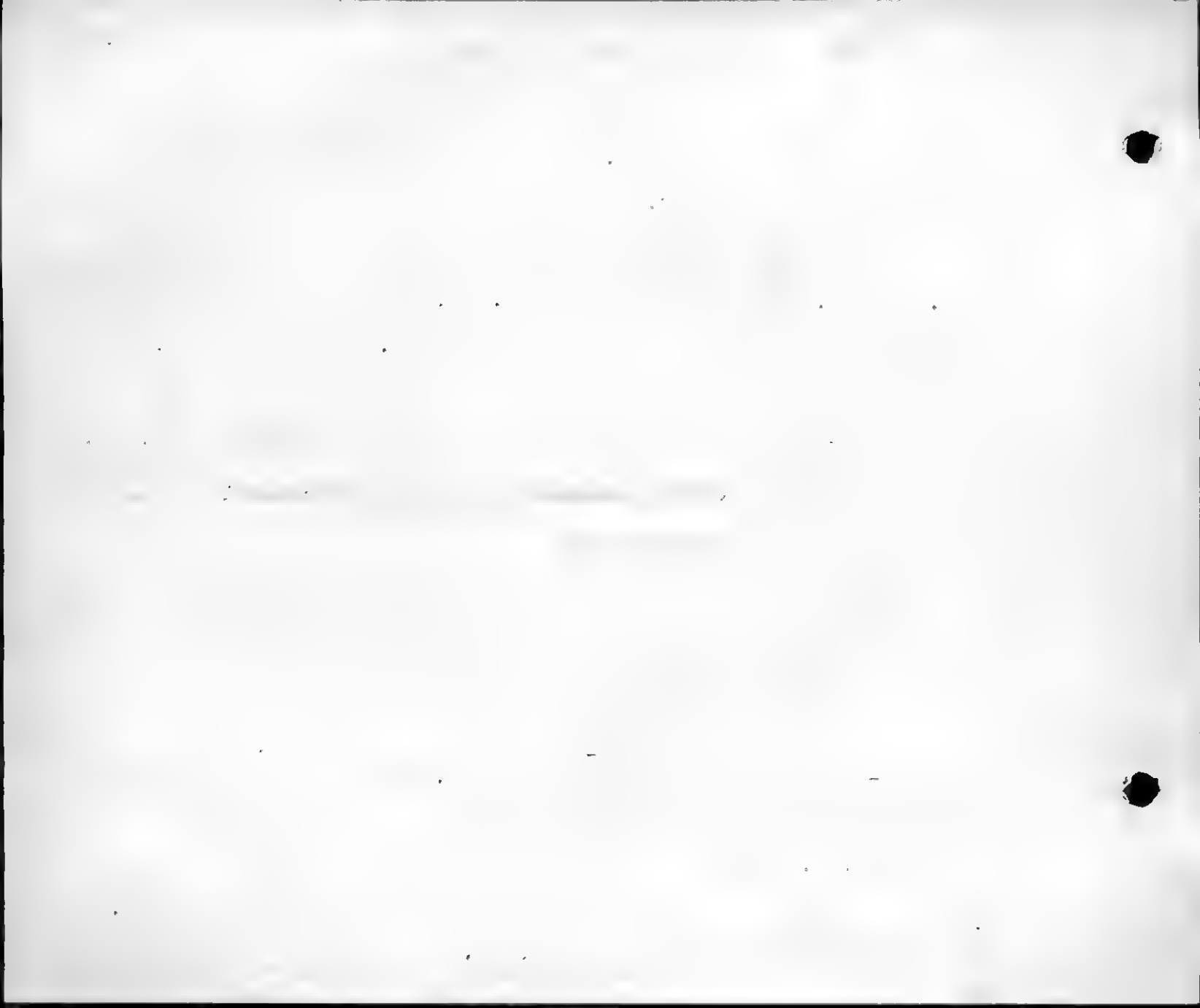
CERTIFICATE OF DEATH

Reg. Dist. No.

04402

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Louise Last Weer | | 4. DATE OF DEATH Month April Day 18 Year 1961 | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 18, 1886 |
| 9. AGE (In years last birthday) yrs. 75 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping | | 10b. KIND OF BUSINESS OR INDUSTRY homemaking | |
| 11. BIRTHPLACE (State or foreign country) Kent Co. Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James Johnston | | 14. MOTHER'S MAIDEN NAME Annie Jefferson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | |
| INFORMANT Miss Marie Weer | | Address Kennedyville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis with left sided paralysis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) ?? | | INTERVAL BETWEEN ONSET AND DEATH 113 days | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12-26 , 19 60 , to April 18 , 19 61 , that I last saw the deceased alive on 4-17 , 19 61 , and that death occurred at 6:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE A. C. Dick | | M.D. | |
| PHYSICIAN'S NAME (Type) A. C. Dick | | Chestertown, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/20/61 | |
| 22c. NAME OF CEMETERY OR CREMATORY Kennedyville Cemetery | | 22d. LOCATION (City, town, or county) (State) Kennedyville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams | | ADDRESS Chestertown, Md. | |
| 24a. REC'D BY REGISTRAR APR 21 '61 | | 24b. REGISTRAR'S SIGNATURE Charles S. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4410

04403

| | | | | | | | |
|--|-------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Kent | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | | | c. LENGTH OF STAY IN 1b -75- 1 Wk. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Frederick Joseph Williams | | | | 4. DATE OF DEATH Month Day Year April 4 1961 | | | |
| 5. SEX M. | 6. COLOR OR RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 15 1875 | 9. AGE (In years last birthday) 85 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hauling | | 10b. KIND OF BUSINESS OR INDUSTRY General | | 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Godfrey Williams | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 215-20-0235 | | 17. INFORMANT Address Joseph Williams Rock Hall, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | | | | | INTERVAL BETWEEN ONSET AND DEATH years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4.1.1961 to 4.4.1961 , that (I) (we) last saw the deceased alive on 4.4.1961 , and that death occurred at 11:40 P. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE A. T. Keefe | | | | 22b. DATE SIGNED 4.5.61 | | | |
| 22c. PHYSICIAN'S NAME (Type) A. T. Keefe | | | | 22d. ADDRESS Chestertown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Apr. 8 1961 | | 23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery | | 23d. LOCATION (City, town, or county) (State) Rock Hall, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams | | | | 25a. REC'D BY REGISTRAR DATE APR 10 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kenna | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

04404

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|---|----------------------------------|---|---|---|---|---|--------------------------|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton | | | | c. LENGTH OF STAY IN 1b 50 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williams Farm | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Isabelle V. Williams | | | | 4. DATE OF DEATH Month Day Year April 11 1961 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 10, 1888 | | 9. AGE (In years lost birthday) yrs. 72 | IF UNDER 1 YEAR Months Days Hours | IF UNDER 24 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Homemaking | | 11. BIRTHPLACE (State or foreign country) Kent county, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Thomas Van Dyke | | | | 14. MOTHER'S MAIDEN NAME Regina Rasin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 215-20-1039 | | INFORMANT George T. Williams, Worton, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic cancer DUE TO Original focus unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary artery disease | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1-26 , 19 61 , to 4-11 , 19 61 , that I last saw the deceased alive on 4-4 , 19 61 , and that death occurred at 6:10 p.m. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE A. C. Dick | | | | ADDRESS (Street, city or town, state) Chestertown, Md. 4-12-61 | | | |
| PHYSICIAN'S NAME (Type) Dr. A. C. Dick | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Apr. 14/61 | | 22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery | | 22d. LOCATION (City, town, or county) (State) Chestertown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams ADDRESS Chestertown, Md. | | | | 24a. REC'D BY REGISTRAR APR 17 '61 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Memorandum for the Director
Subject: [Illegible]

Reference is made to [Illegible]
[Illegible text continues]

It is recommended that [Illegible]
[Illegible text continues]

Very respectfully,
[Illegible Signature]

Enclosure
[Illegible text continues]